SMILES TODAY DENTAL

Please download and complete this form to be returned to the office.

PATIENT INFORMATION

NAME: _____ ☐ MALE ☐ FEMALE
LAST FIRST MIDDLE

SOCIAL SECURITY #: _____ MARITAL STATUS: ☐ S ☐ M DOB: _____ AGE: _____

TELEPHONE (HOME): ( ) _____ CELL: ( ) _____

TELEPHONE (WORK): ( ) _____ EMAIL: _____

ADDRESS: _____
STREET NAME APT. # CITY STATE ZIP CODE

EMPLOYER: _____

REFERRAL INFORMATION

☐ TV ☐ MAIL ☐ POSTCARD ☐ INTERNET ☐ YELLOW PAGES ☐ WELFARE OFFICE: _____
NAME OF REP.

☐ FRIEND OR RELATIVE (NAME): _____ ☐ OTHER: _____

SPOUSE OR RESPONSIBLE PARTY INFORMATION

THE FOLLOWING IS FOR: ☐ THE PATIENT'S SPOUSE ☐ THE PATIENT'S PARENT ☐ PERSON RESPONSIBLE FOR PAYMENT

NAME: _____ ☐ MALE ☐ FEMALE ☐ MARRIED ☐ SINGLE

SOCIAL SECURITY #: _____ DATE OF BIRTH: _____

HEALTH INFORMATION

DATE OF LAST DENTAL VISIT: _____ REASON FOR THE VISIT: _____

DO YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING? CHECK THOSE THAT APPLY:

☐ AIDS	☐ GLAUCOMA	☐ RESPIRATORY PROBLEMS
☐ ANEMIA	☐ HEAD INJURIES	☐ RHEUMATIC FEVER
☐ ARTHRISTIS	☐ HEART DISEASE	☐ RHEUMATISM
☐ ASTHMA	☐ HEART MURMUR	☐ SINUS PROBLEMS
☐ ALLERGIES _____	☐ HEPATITIS A ☐ B ☐ C ☐	☐ STOMACH PROBLEMS
☐ ARTIFICAL JOINTS	☐ HIGH BLOOD PRESSURE	☐ STROKE
☐ BLOOD DISEASE	☐ JAUNDICE	☐ TUBERCULOSIS
☐ CANCER	☐ KIDNEY DISEASE	☐ ULCERS
☐ DIABETES	☐ LIVER DISEASE	☐ VENERAL DISEASE
☐ DIZZINESS	☐ PACEMAKER	☐ CODEINE ALLERGY
☐ EPILEPSY	☐ GROWTHS	☐ PENICILLIN ALLERGY
☐ FAINTING	☐ ARE YOU PREGNANT: ☐ YES ☐ NO	☐ OTHER: _____
☐ RADIATION TREATMENT	DUE DATE: _____	☐ OTHER: _____

ARE YOU UNDER THE CARE OF A PHYSICIAN? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN: _____

NAME OF PHYSICIAN: _____ TELEPHONE #: ( ) _____

ARE YOU TAKING ANY MEDICATIONS, PILLS OR DRUGS? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN: _____

DO YOU TAKE ANY ***BLOOD THINNERS*** ? ☐ YES ☐ NO ☐ ASPIRIN ☐ PLAVIX ☐ COUMADIN OTHER: _____

TO THE BEST OF MY KNOWLEDGE, ALL OF THE PRECEDING ANSWERS AND INFORMATION PROVIDED ARE TRUE AND CORRECT. IF I HAVE ANY CHANGES IN MY HEALTH, I WILL INFORM THE DOCTORS AT THE NEXT APPOINTMENT WITHOUT FAIL.